

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

06163

Reg. Dist. No.

6200

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LOTTIE M.</u> Middle <u>BAXTER</u> Last <u>BAXTER</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 15-1890</u> 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>WILLIAM THOMPSON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. MOTHER'S MAIDEN NAME <u>ANNA CLENDANIEL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>220-32-9354B</u>		17. INFORMANT <u>WILLIAM A. BAXTER-STEVENSVILLE</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>general arteriosclerosis general + cerebral</u> DUE TO <u>Diabetes mellitus</u> (c) <u>about 15 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral thrombosis 1958 + 1959 - hypertensive Cardio-renal disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>10 years</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 10</u> , 19 <u>60</u> , to <u>May 24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 23</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, state) <u>Stevensville, Md.</u> DATE SIGNED <u>May 24, 1960</u>	
PHYSICIAN'S NAME (Type) <u>THEODOR SATTELMAIER</u>		<u>STEVENSVILLE, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 26</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane Church Hill, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAY 31 1960</u>	24b. REGISTRAR'S SIGNATURE <u>Carroll S. Harris</u>

6193

CERTIFICATE OF DEATH

06164

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY QUEEN ANNES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CENTREVILLE		c. LENGTH OF STAY IN lb 8 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X CENTREVILLE	
3. NAME OF DECEASED (Type or print) JAMES ALLEN BAYNARD		f. STREET ADDRESS RAILROAD AVE.	
4. DATE OF DEATH MAY 28 1960		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 21, 1910
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR: Months 1 Days 28 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Tennant		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Baynard		14. MOTHER'S MAIDEN NAME Carrie Stranahan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-4476	
17. INFORMANT David Baynard		Address Route #4 Easton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 410X DUE TO CARDIAC CACHEXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) CHRONIC PASSIVE CONGESTION DUE TO (c) RHEUMATIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 8 YEARS 10-15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DEC. 1959 to 28 MAY, 1960 , that I last saw the deceased alive on 28 MAY, 1960 , and that death occurred at 7:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Kent Young M.D.		ADDRESS (Street, city or town, state) 105 CHESTERFIELD AVE. CENTREVILLE, MD.	
PHYSICIAN'S NAME (Type) J. KENT YOUNG M.D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-31-60	
22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR JUN 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hous	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

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UNITED STATES OF AMERICA



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may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 263 5-23-60 et

6201

CERTIFICATE OF DEATH

06165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHURCH HILL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHURCH HILL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1. d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>DANIEL F.</u> First <u>BUTLER</u> Middle <u></u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN BUTLER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH HARRIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-80-319</u>	
17. INFORMANT <u>ALCONARD BUTLER</u>		Address <u>CHURCH HILL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Cerebral</u> DUE TO <u>+ Generalized</u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u> years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage - 2 mo ago</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 12, 1960</u> to <u>May 11, 1960</u> that I last saw the deceased alive on <u>May 11, 1960</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Rayton</u>		M.D. <u>1045 Liberty</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Rayton</u>		DATE SIGNED <u>Centerville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>MAY 15</u>	<u>CHURCH HILL</u>	<u>CHURCH HILL MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 17 '60</u>	
ADDRESS <u>Church Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> <u>Christina S. House</u>	

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6199

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Annes, Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centerville, Md.				c. LENGTH OF STAY IN 1b 1 Year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Harriet Rebecca White Calloway				4. DATE OF DEATH Month Day Year 5 10 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/14/1868.		9. AGE (In years lost birthday) 91 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Somerset Co., Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		INFORMANT Address Mr. Oliver Wright, Cambridge, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis in Coronary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour 4 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 10 1960 to May 10 1960 that I last saw the deceased alive on May 10 1960 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Centerville Maryland DATE SIGNED 5-10-60							
ACTUAL SIGNATURE C. R. Bayton M.D.				PHYSICIAN'S NAME (Type) C. R. Bayton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/12/1960.		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Memorial Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland.				24a. REC'D BY REGISTRAR DATE MAY 16 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7-10-1960

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CERTIFICATE OF DEATH

06167

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Eaton</u> Last <u>Eaton</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>FEM</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15 - 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>17</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>MRS. MARY WATERS - FRANKFORD DEL.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Diabetes - Mellitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>260X</u> (c) <u>260X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>May</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>May 1</u> , 19 <u>60</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irwin D. Hoyt</u> M.D.		DATE SIGNED <u>Queenstown Md. 5/7/60</u>	
PHYSICIAN'S NAME (Type) <u>Irwin G. Hoyt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '60</u>	
ADDRESS <u>Church Hill</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

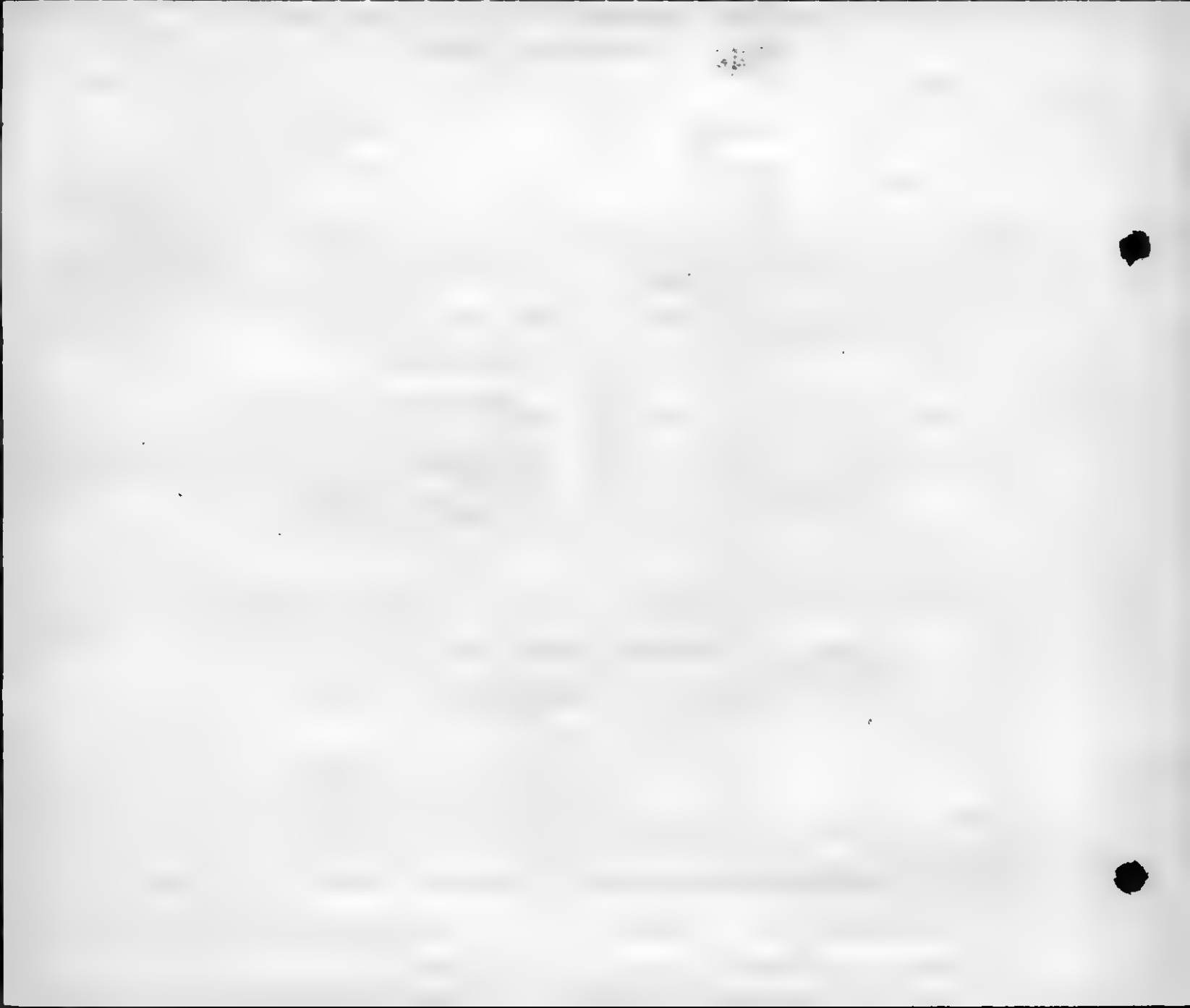
6203

CERTIFICATE OF DEATH

Reg. Dist. No.

06168

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTERVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>W</u> Middle <u>Gibbs</u> Last		4. DATE OF DEATH Month <u>MAY</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>about 80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>CLARA HARRISON UNKNOWN</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>CLARA HARRISON</u> Address <u>RURAL CENTERVILLE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to chronic hypernatremia? Ca 9 months</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>72 hours</u> <u>2 weeks</u> <u>3 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>60</u> , to <u>May 26</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>May 26</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>John R. Smith, Jr.</u> M.D. <u>Box 66</u> ADDRESS (Street, city or town, state) <u>Cough House Square</u> DATE SIGNED <u>5/30/60</u> PHYSICIAN'S NAME (Type) <u>John R. Smith, Jr.</u> <u>Centerville, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-31-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>RICH NECK</u>	22d. LOCATION (City, town, or county) (State) <u>NEAR LHESTERTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>



6204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>12yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Willie</u> Middle <u>James</u> Last <u>Kelley</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shucker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-5824</u>	
17. INFORMANT Address <u>Mary Kelley Grasonville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>51</u> , to <u>May</u> 19 <u>60</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>60</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin D. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Quantico, Md.</u> DATE SIGNED <u>5/3/60</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>5/8/60</u>	<u>Grasonville, Md.</u>	<u>Grasonville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dodshill, Porton, Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>MAY 11 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06170
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Somerset</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>12 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingston</u> <u>17X-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Van</u> Last <u>Wilson</u>			4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 19, 1924</u>		9. AGE (in years last birthday) <u>36</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oysterman</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>MARTIN Wilson</u>		
14. MOTHER'S MAIDEN NAME <u>MARY Hayman</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>218-16-5490</u>			17. INFORMANT <u>Emmie Whittington, St. Michaels, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Cornary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary Arteriosclerotic Disease</u> (c) <u>Obesity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>3 years</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-25-60</u>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem</u>	
22d. LOCATION (City, town, or county) <u>Easton</u>		22e. (State) <u>Md.</u>		22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Shiel, Easton, Md.</u>		ADDRESS <u>Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 1 '60</u>	

NEW YORK STATE
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

NEW YORK STATE
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of Birth: Jan 1, 1900

5. Place of Birth: New York City

6. Date of Death: Jan 15, 1945

7. Place of Death: Home

8. Cause of Death: Heart Disease

9. Manner of Death: Natural

10. Signature of Medical Examiner: [Signature]

11. Date of Examination: Jan 16, 1945

12. Signature of Registrar: [Signature]

13. Date of Registration: Jan 17, 1945